DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G134	A. BUILDING _____ B. WING _____	12/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEHAVIOR RESEARCH ASSOCIATES	4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was initiated on December 21, 2010 and was concluded on December 23, 2010. A sample of three clients was selected from a population of six men with various cognitive and intellectual disabilities. This survey was initiated utilizing the fundamental process. The findings of the survey were based on observations and interviews with clients and staff in the home and at three day programs, as well as a review of client and administrative records, including incident reports.	W 000	RECEIVED 1/24/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement its policies to ensure the health and safety for two of the six clients residing in the facility. (Clients #2 and #4) The finding includes: Nursing staff failed to implement the facility's incident management policies (specifically, to complete an incident report for all incidents when they become known), as evidenced by the following: [Cross-refer to W368.1] On December 23, 2010, at 9:47 a.m., the facility's incident management coordinator (IMC) stated that she was unaware of	W 149	W149 All of the nurses that pass medications were retrained on incident reporting and other relevant topics. Training will be repeated at minimum every six months and as needed based on issues uncovered during internal management audits. BRA has developed a new audit tool that will be used by the RN to audit the medication administration records at minimum monthly... 1-4-11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	Continued From page 1 any medication errors that may have occurred two days earlier. She stated that medication errors were considered "Reportable" incidents and according to their policies, nursing staff should have completed an incident report. Moments later, the IMC presented the applicable policy (not dated) which, on page 8, stated that all medication errors, including documentation errors, should be documented as a "Reportable" incident, using the approved incident report form. She also stated that she had just spoken with the RN, who confirmed that on the morning of December 21, 2010, Client #4 had not received Loratadine 10 mg, Client #2 had received Loratadine even though it had been previously discontinued and that a nurse had improperly documented the medication administrations on Client #2's and Client #4's Medication Administration Records. She stated that nurse(s) having direct knowledge of the medication errors were responsible for completing an incident report form. It should be noted that review of staff in-service training records, on December 23, 2010, at approximately 12:30 p.m., revealed that nursing staff (and others) had received training on their incident management policies at various times in March 2010 and June 2010. The failure by nursing staff to complete an incident report timely revealed that the training received 6 months earlier had not been effective.	W 149		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	W 189		

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W 189	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that staff were effectively trained on reporting damaged wheelchairs to supervisors timely, for 19 of the 19 direct support staff employed by the facility. The findings include: 1. On December 21, 2010, Client #1 was observed at his day program, from 1:00 p.m. - 1:42 p.m. At 1:12 p.m., when asked about the condition of Client #1's wheelchair, his assigned 1:1 direct support staff person stated that it was in good working order. She said a technician had made some repairs approximately 2 1/2 weeks earlier and that it was operational. However, a minute later (at 1:13 p.m.), inspection of the client's wheelchair revealed that the small plastic wheels were missing from the end of the right anti-tipper device. The 1:1 staff said she was previously unaware that any parts were missing. On December 23, 2010, at 10:53, the QMRP was asked about the facility's policies and systems for monitoring and repairing clients' adaptive equipment, specifically wheelchairs. She stated that direct support staff were expected to report any problems with adaptive equipment to the house manager (HM) or to the QMRP. The HM routinely inspected wheelchairs on a monthly basis, documenting the inspection on a 2-page form. The QMRP said she was not aware of any missing parts on Client #1's wheelchair. The QMRP then asked the HM, who also stated that she was not aware of any missing parts on Client #1's wheelchair. When the 1:1 staff person was	W 189	W189 Staff will be retrained on monitoring the condition of adaptive equipment and timely reporting to the RN on...1-20-11 Staff will continue to be required to examine adaptive equipment and report any issues they uncover but BRA has developed a new Adaptive Equipment Auditing and Tracking form that will be used to monitor the condition of all adaptive equipment on a monthly basis. This new form will be used by the RN and QMRP, raising the level of professionalism for these monthly reviews...1-20-11.	

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W 189	Continued From page 3 reached by telephone, she informed the HM that the right anti-tipper wheels were missing and then acknowledged that she "forgot" to report it two days earlier. 2. On December 23, 2010, at 11:20 a.m., review of Daily Progress Notes that were entered into Client #1's record by each shift revealed that for the past 10 days, staff routinely had checked "yes" at the place designated for "adaptive equipment working." None of the shift progress notes documented any concerns regarding the condition of Client #1's wheelchair. [Note: Client #1 received 1:1 staffing support 16 hours daily, during awake hours.] 3. On December 23, 2010, beginning at 11:38 a.m., review of staff in-service training records revealed no documented evidence that the facility provided training on wheelchair maintenance for its direct support staff. Subsequent interview with the FC indicated that while she thought that staff had received training, she acknowledged that documentation of said training was not available for review.	W 189		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs, for four of the six clients residing in the facility. (Clients #1, #2, #3 and #4)	W 331		

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W 331	Continued From page 4 The findings include: 1. [Cross-refer to W368] The facility's nursing staff failed to ensure that all drugs were administered in compliance with the physician's orders. On December 21, 2010, Client #4 did not receive one of his prescribed medications, while Client #2 received a medication that previously had been discontinued. 2. [Cross-refer to W369.1] On December 22, 2010, at approximately 2:20 p.m., interview with the facility's registered nurse (RN) revealed that clients' medications routinely were delivered from the pharmacy to the agency's corporate office. An LPN who worked solely in that office would then process the medications received, including blister packs for clients residing in this facility, and have them brought to the facility. Upon determination that there was a blister pack of Loratadine 10 mg for Client #2 for December 2010 (even though it was discontinued in November) and no blister pack of Loratadine 10 mg for Client #4 (even though it remained a current order), the RN stated that this was "unacceptable" and would address it with her nursing team. 3. The facility's nursing services failed to implement an effective system to ensure that Client #1's fluid intake was consistently monitored and documented, as evidenced by the following: During the morning medication pass on December 21, 2010, at 8:23 a.m., Client #1 received his medications mixed with chocolate pudding. Beginning at 8:58 a.m., review of the client's December 2010 POs revealed that he was to receive 30 cc of water with his	W 331	W331 1 and 2 BRA will insure that medications received routinely are compared to the physician's orders and MARs to insure that the medications received match the medication regimens of each individual supported. The RN will conduct these reviews in conjunction with the LPN and will review the physician's orders and MARs with the PCP as well during monthly visits... 1-20-11 New medications or treatments suggested by specialists or after hospital visits or through any other vehicles will be reviewed with the PCP by the RN and will be implemented only after receiving approval from the PCP... 1-20-11 3. The medication administration nurse that failed to provide water to client #1 was re-trained to insure the medication pass procedures are followed consistently. All medication nurses received the training... 1-4-11 The RN will observe medication administration at minimum once weekly to insure that all medications are properly administered routinely... 1-24-11	

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W 331	Continued From page 5 medications. He did not, however, receive any water at the medication pass observed that morning. At 9:12 a.m., the medication nurse was asked about his fluid intake. She confirmed that he did not receive water that morning with his medications. She stated that sometimes she offered him water if there was some left over from his breakfast. She further indicated that she never measured water given with medications and that she did not record water intake on his Medication Administration Records (MARs). Subsequent review of Client #1's MARs confirmed that nursing staff were not documenting 30 cc of water was his medications. [Note: In addition to the 30 cc of water with medications, the client's POs reflected an order to provide 250 cc of fluids at breakfast, lunch, dinner and snack. Staff was observed measuring 250 cc of fluids earlier that morning at breakfast, in accordance with the POs. Later that day, at 1:10 p.m., Client #1's assigned 1:1 staff person stated that he had received 250 cc with his lunch at the day program.] 4. The facility's nursing services failed to coordinate services closely with Client #3's day program nurse and the the primary care physician to ensure timely and accurate preventive services, as evidenced by the following: During the morning medication administration on December 21, 2010, at 8:40 a.m., the licensed practical nurse (LPN) was observed making several attempts to administer 1 drop of Murp eye drops into Client #3's right eye. The client, however, was combative and refused to	W 331	4. All of the medication administration nurses were trained on all issues involving the administration of the eye drops including (1) insuring that the physician's orders are accurate and followed; (2) reporting refusal to accept medication (3) properly documenting and implementing verbal orders (4) coordination with day program services The eye drops have been discontinued at this time per the PCPs order... 1-14-11	

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W 331	Continued From page 6	W 331		

cooperate. Eventually, the LPN stopped trying and the client did not receive the eye drop.

a. On December 21, 2010, at 10:05 a.m., review of Client #3's current physician's orders (POs), dated December 1, 2010, indicated "Muro 128 5% Eye Drops. Instill 1 drop 3 times daily into left eye." The morning nurse, however, had tried administering the drop to his right eye.

b. Review of Client #3's POs from previous months revealed that nursing staff failed to transcribe the orders for Muro eye drops accurately.

(1) While his current POs, dated December 1, 2010, indicated the Muro eye drops were to be administered to his left eye, his December 2010 Medication Administration Record (MAR) had been altered; a line was drawn through the word left and "right" was written below it. On December 22, 2010, at 3:22 p.m., review of the client's progress notes from December 2009 revealed that he was evaluated at a hospital emergency room (ER) for a swollen left eye and received sutures. The ER discharge papers indicated the Muro eye drops were ordered for the left eye. On December 22, 2010, at 3:25 p.m., neither the written record nor concurrent interviews with the afternoon LPN and the registered nurse (RN) could explain why the order had been altered to say "right" eye.

(2) On December 22, 2010, beginning at 2:59 p.m., continued review of Client #3's POs and MARs for the period December 2009 - December 2010 revealed that some of his POs indicated the eye drop should be administered to his left eye (March 2010, May, 2010, June 2010, August

W331

In the future the nurse coordinator will ensure that if there are any new orders a note will be sent to the day program with a follow-up call to the day program nurse to ensure accuracy. The RN Coordinator and QMRP will visit the day program on an on-going basis to ensure medication orders are accurate to also ensure that all areas are addressed according to the individuals needs.....02-02-11

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W 331	Continued From page 7 2010, October 2010 and November 2010), whereas POs for April 2010 showed a line drawn through the word left, and "right" written instead. Similarly, some of the client's monthly MARs reflected designated administration times of 6am, noon and 6pm, while other MARs simply reflected the word "treatment" without indicating specific times. (3) Client #3's POs for July 2010 and September 2010 had the notation of "D/C'd" written for the Muro eye drops. The alterations, however, were not dated. On December 22, 2010, at 3:22 p.m., there was no corresponding telephone order in his chart. Review of the client's nurse progress notes failed to indicate why, or by whom, an order was given to discontinue the Muro eye drops. In addition, Client #3's POs, dated October 1, 2010, November 1, 2010 and December 1, 2010 all reflected "Muro 128 5% Eye Drops. Instill 1 drop 3 times daily into left eye." c. On December 22, 2010, beginning at 2:59 p.m., review of Client #3's POs for the period December 2009 - December 2010 revealed that an LPN, the RN and the primary care physician had all signed the monthly POs. There was no indication, however, that the client's medical team identified transcription errors (left eye, right eye, designated treatment times, etc.) prior to this survey. d. On December 22, 2010, at 11:07 a.m., Client #3's day program nurse stated that the client did not receive any medications or treatments during his day there. At 11:46 a.m., she presented Client #3's POs for October, November and December 2010. They all reflected "Muro 128 5% Eye Drops. Instill 1 drop 3 times daily into left	W 331		

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W 331	Continued From page 8 eye." The nurse, however, stated that she had not been instructed by the home to administer eye drops and because the orders read "three times daily," she would not administer them without first receiving orders to do so. When informed that on the previous morning (December 21, 2010, at 10:10 a.m.), the client's MAR for December 2010 showed the designated times included a noon administration, the day program nurse expressed her willingness to administer the eye drops. When interviewed in the home later that afternoon, at 1:55 p.m., both the RN and the QMRP acknowledged that neither of them had addressed Client #3's order for Muro eye drops with the day program. It should be noted that on December 22, 2010, at 3:30 p.m., the primary care physician discontinued the Muro eye drops after receiving a telephone inquiry from the facility's RN seeking clarification. There was no evidence that the facility's nursing services effectively monitored his POs and MARs to ensure their accuracy and/or to determine the continued need for prescribed treatments such as Muro eye drops.	W 331		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all drugs were administered in compliance with the physician's orders, for two of the six clients	W 368		

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W 368	Continued From page 9 residing in the facility. (Clients #2 and #4) The findings include: Observation of the morning medication administration pass on December 21, 2010 revealed that Client #4 did not receive one of his prescribed medications, while Client #2 received one medication that previously had been discontinued, as evidenced by the following: On December 21, 2010, Client #4 was observed receiving his medications between 8:17 a.m. - 8:22 a.m. He received ten medications. Loratadine, however, was not one of them. Client #2 then received his medications between 8:26 a.m. - 8:30 a.m., including Loratadine 10 mg. Beginning at 8:58 a.m., review of Client #4's December 2010 physician's orders (POs) and Medication Administration Record (MAR) revealed an order for Loratadine 10 mg every morning. Client #2's December 2010 POs and MARs indicated that he previously had been prescribed Loratadine 10 mg every morning. The order, however, was discontinued, effective November 30, 2010. At approximately 9:30 a.m., the medication nurse confirmed that she had administered Loratadine 10 mg to Client #2. She then retrieved a blister pack of Loratadine 10 mg that was labeled with Client #2's name. Further review of the blister pack revealed that the seal was broken on each of the bubbles marked for December 1 - 21, 2010, thereby indicating that a tablet had been removed/ administered every morning that month. Moments later, inspection of the medication closet revealed no evidence of a similar blister	W 368	W368 BRA will insure that medications received routinely are compared to the physician's orders and MARs to insure that the medications received match the medication regimens of each individual supported. The RN will conduct these reviews in conjunction with the LPN and will review the physician's orders and MARs with the PCP as well during monthly visits...1-20-11 New medications or treatments suggested by specialists or after hospital visits or through any other vehicles will be reviewed with the PCP by the RN and will be implemented only after receiving approval from the PCP...1-20-11	

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W 368	Continued From page 10 pack of Loratadine 10 mg labeled for Client #4. During the Exit conference on December 23, 2010, the facility's registered nurse indicated that her (ongoing) investigation into the morning medication pass observations of December 21, 2010 had confirmed that Client #4 was without a blister pack of Loratadine 10 mg, prior to the afternoon of December 21, 2010.	W 368		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all drugs were administered without error, for two of the six clients residing in the facility. [Clients #2 and #4] The findings include: The facility failed to implement an effective system to ensure that clients received medications as prescribed and/or did not receive medications after the medication was discontinued, as evidenced by the following: [Cross-refer to W368.1] During the morning medication pass on December 21, 2010, Client #2 was observed receiving Loratadine 10 mg even though it had been discontinued on November 30, 2010. Client #4, who was prescribed Loratadine 10 mg daily, did not receive it that morning. Beginning at 8:58 a.m., review the clients'	W 369	W369 In addition to the responses for W368 above, the RN will review the MARs weekly to insure there are no medication errors, gaps or issues...1-24-11	

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W 369	Continued From page 11 December 2010 MARs showed no evidence that nursing staff had identified the error prior to the December 21, 2010 survey observations. Nurses had documented administering Loratadine 10 mg to Client #4 every morning that month, even though there was no blister pack of Loratadine 10 mg labeled for his use. Likewise, Client #2's December 2010 MAR did not reflect nurses' initials on December 21, 2010 (or any morning that month) for Loratadine 10mg, even though the nurse was observed administering it to Client #2 a short time earlier. During the Exit conference on December 23, 2010, the facility's registered nurse (RN) stated that an internal investigation remained open. Her preliminary findings suggested that Client #4 had received his prescribed Loratadine 10 mg each morning December 1 - 20, 2010. She indicated that the only morning that Client #2 received the Loratadine instead of Client #4 was on the morning of December 21, 2010. She acknowledged that the survey findings revealed systemic problems which she would address with the entire nursing team. The facility's investigative findings and report were to follow.]	W 369		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record	W 436		

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	09G134	A. BUILDING _____ B. WING _____	12/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEHAVIOR RESEARCH ASSOCIATES	4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019

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W 436	Continued From page 12 review, the facility failed to ensure that adaptive equipment was furnished and maintained in good condition as prescribed, for one of the two clients (out of six) who utilized wheelchairs for mobility. (Client #1) The findings include: 1. Interviews and review of Client #1's record revealed that the facility failed to address timely the physical therapist's recommendation that he receive a custom wheelchair, as evidenced by the following: On December 23, 2010, beginning at 11:38 a.m., review of Client #1's physical therapy (PT) records revealed that a PT Evaluation, dated January 22, 2010, indicated that his wheelchair "sling seating system" did "not fully support his body." The PT stated that the client "may benefit from a custom wheelchair." In an updated evaluation, dated May 14, 2010, the PT recommended a custom wheelchair. Client #1's Annual PT Evaluation, dated June 30, 2010, recommended the client "will benefit from a custom wheelchair. Obtain a 719a form." Review of the client's Individual Support Plan, dated July 13, 2010, revealed that his interdisciplinary team (IDT) adopted the PT's recommendation for a "customized wheelchair." Continued review of the record, however, failed to show evidence that the facility had pursued the new wheelchair. At 12:00 p.m., concurrent interviews with the QMRP, HM and the registered nurse (RN) revealed that an LPN (who worked solely out of the agency's corporate office) handled 719a forms and requests for adaptive equipment. During the interview, the RN spoke with the LPN	W 436	W436 BRA began to pursue the needed wheelchair in June of 2010 as evidenced by the NRH summary attached. BRA did not have this documentation during the survey but subsequently requested it and received it after the survey was completed. Neither the RN nor QMRP notes reflected the follow up that had been done to that point and the Program Manager has addressed this with both the QMRP and RN. At this point, the new wheelchair has been developed and has been received. The PT has trained staff and the client on the use of the chair...1-3-11.	

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W 436	Continued From page 13 by telephone. The telephone conversation, however, failed to clarify whether or not a 719a form had ever been signed by the primary care physician and forwarded to the insurance carrier. At 2:15 p.m., review of Client #1's Annual Nursing Evaluation, dated July 10, 2010, revealed that the evaluation failed to reflect the status of the client's recommended custom wheelchair. The QMRP's monthly summary reports also failed to reflect the status of his wheelchair. At 2:20 p.m., the RN and the QIDP both acknowledged that they had not been actively monitoring Client #1's wheelchair needs and did not know whether a new chair had been ordered. There was no evidence that the facility sought to acquire a customized wheelchair since the PT's recommendation was adopted by the IDT on July 13, 2010, five months earlier. 2. [Cross-refer to W189.] During the Entrance conference on December 21, 2010, at approximately 11:36 p.m., interview with the QMRP and the facility coordinator (FC) indicated that the wheelchair used by Client #1 was in good repair. However, at1:13 p.m. later that day, inspection of the client's wheelchair revealed that the small plastic wheels were missing from the end of the right anti-tipper device.	W 436		

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I 000	INITIAL COMMENTS A licensure was initiated on December 21, 2010 and was concluded on December 23, 2010. A sample of three residents was selected from a population of six men with various cognitive and intellectual disabilities. This survey was initiated utilizing the fundamental process. The findings of the survey were based on observations and interviews with clients and staff in the home and at three day programs, as well as a review of resident and administrative records, including incident reports.	I 000		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure that staff were effectively trained on reporting damaged wheelchairs to supervisors timely, for 19 of the 19 direct support staff employed by the facility. The findings include: 1. On December 21, 2010, Resident #1 was observed at his day program, from 1:00 p.m. - 1:42 p.m. At 1:12 p.m., when asked about the condition of Resident #1's wheelchair, his assigned 1:1 direct support staff person stated that it was in good working order. She said a technician had made some repairs approximately 2 1/2 weeks earlier and that it was operational. However, a minute later (at 1:13 p.m.), inspection of the resident's wheelchair revealed that the small plastic wheels were missing from the end of the right anti-tipper device. The 1:1 staff said she	I 222	Chapter 35 3510.3 Staff will be retrained on monitoring the condition of adaptive equipment and timely reporting to the RN on...1-20-11 Staff will continue to be required to examine adaptive equipment and report any issues they uncover but BRA has developed a new Adaptive Equipment Auditing and Tracking form that will be used to monitor the condition of all adaptive equipment on a monthly basis. This new form will be used by the RN and QMRP, raising the level of professionalism for these monthly reviews...1-20-11.	

LABDRATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Linda Graham, Program Supervisor TITLE (X6) DATE

01/21/11

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I 222	Continued From page 1 was previously unaware that any parts were missing. On December 23, 2010, at 10:53, the QMRP was asked about the facility's policies and systems for monitoring and repairing residents' adaptive equipment, specifically wheelchairs. She stated that direct support staff were expected to report any problems with adaptive equipment to the house manager (HM) or to the QMRP. The HM routinely inspected wheelchairs on a monthly basis, documenting the inspection on a 2-page form. The QMRP said she was not aware of any missing parts on Resident #1's wheelchair. The QMRP then asked the HM, who also stated that she was not aware of any missing parts on Resident #1's wheelchair. When the 1:1 staff person was reached by telephone, she informed the HM that the right anti-tipper wheels were missing and then acknowledged that she "forgot" to report it two days earlier. 2. On December 23, 2010, at 11:20 a.m., review of Daily Progress Notes that were entered into Resident #1's record by each shift revealed that for the past 10 days, staff routinely had checked "yes" at the place designated for "adaptive equipment working." None of the shift progress notes documented any concerns regarding the condition of Resident #1's wheelchair. [Note: Resident #1 received 1:1 staffing support 16 hours daily, during awake hours.] 3. On December 23, 2010, beginning at 11:38 a.m., review of staff in-service training records revealed no documented evidence that the facility provided training on wheelchair maintenance for its direct support staff. Subsequent interview with the FC indicated that while she thought that staff had received training, she acknowledged that	I 222		

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I 222	Continued From page 2 documentation of said training was not available for review.	I 222		
I 399	3520.2(i) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (l) Speech and language therapy; and... This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that a copy of professional credentials was maintained for each individual providing professional services at the GHMRP, as required by District of Columbia law, in the following disciplines or area: (i) Speech and Language Therapy. The finding is: Review of the personnel records on December 22, 2010, beginning at 4:29 p.m., revealed that a current license/professional certification was not available for the Speech Language Therapist and/or her assistant. At approximately 5:10 p.m., the GHMRP's facility coordinator confirmed that the license/ professional credentialing for the Speech Language Therapist and/or her assistant	I 399	3520.2 (i) BRA will obtain a current license from the speech pathologist for the district of Columbia once her certification for the district is completed. If not done in a timely manner a new speech pathologist will be recruited by...2-30-11 BRA will review the personnel records quarterly in order to follow up proactively on such concerns...2-26-11	

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I 399	Continued From page 3 were not available for review. At 5:15 p.m., a search of professional licensing records online revealed no evidence that the consulting Speech Language Therapist was licensed to practice in the District of Columbia, in accordance with: Title 3. Chapter 12 of the District of Columbia Official Code SUBCHAPTER V. LICENSING, REGISTRATION, OR CERTIFICATION OF HEALTH PROFESSIONALS § 3-1205.01. License, registration, or certification required. (a) A license issued pursuant to this chapter is required to practice medicine, acupuncture, chiropractic, registered nursing, practical nursing, dentistry, dental hygiene, dietetics, marriage and family therapy, massage therapy, naturopathic medicine, nutrition, nursing home administration, occupational therapy, optometry, pharmaceutical detailing, pharmacy, physical therapy, podiatry, psychology, social work, professional counseling, audiology, speech-language pathology, respiratory care, advanced practice addiction counseling, or to practice as an anesthesiologist assistant, physician assistant, physical therapy assistant, polysomnographic technologist, occupational therapy assistant, or surgical assistant in the District, except as otherwise provided in this chapter. No additional information was presented before the survey ended 24 hours later.	I 399		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this	I 500		

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I 500	Continued From page 4 chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: 1. Based on observation, interview and record verification, the GHMRP failed to ensure the residents' right to receive appropriate and necessary nursing services, for four of the six residents of the facility. (Residents #1, #2, #3 and #4) The findings include: a. [Cross-refer to Federal Deficiency Report - Citation W368] The facility's nursing staff failed to ensure that all drugs were administered in compliance with the physician's orders. On December 21, 2010, Resident #4 did not receive one of his prescribed medications, while Resident #2 received a medication that previously had been discontinued. b. [Cross-refer to Federal Deficiency Report - Citation W369.1] On December 22, 2010, at approximately 2:20 p.m., interview with the facility's registered nurse (RN) revealed that residents' medications routinely were delivered from the pharmacy to the agency's corporate office. An LPN who worked solely in that office would then process the medications received, including blister packs for residents residing in this facility, and have them brought to the facility. Upon determination that there was a blister pack of Loratadine 10 mg for Resident #2 for December 2010 (even though it was discontinued in November) and no blister pack of Loratadine 10 mg for Resident #4 (even though it remained a current order), the RN stated that this was "unacceptable" and would address it with her	I 500	3523.1 BRA will insure that medications received routinely are compared to the physician's orders and MARs to insure that the medications received match the medication regimens of each individual supported. The RN will conduct these reviews in conjunction with the LPN and will review the physician's orders and MARs with the PCP as well during monthly visits...1-20-11 New medications or treatments suggested by specialists or after hospital visits or through any other vehicles will be reviewed with the PCP by the RN and will be implemented only after receiving approval from the PCP...1-20-11 BRA will insure that medications received routinely are compared to the physician's orders and MARs to insure that the medications received match the medication regimens of each individual supported. The RN will conduct these reviews in conjunction with the LPN and will review the physician's orders and MARs with the PCP as well during monthly visits...1-20-11 New medications or treatments suggested by specialists or after hospital visits or through any other vehicles will be reviewed with the PCP by the RN and will be implemented only after receiving approval from the PCP...1-20-11	

Health Regulation Administration

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I 500	Continued From page 5 nursing team. c. [Cross-refer to Federal Deficiency Report - Citation W331.3] The facility's nursing services failed to implement an effective system to ensure that Resident #1's fluid intake during the administration of medications was documented in his record. d. The facility's nursing services failed to coordinate services closely with Resident #3's day program nurse and the the primary care physician to ensure timely and accurate preventive services, as evidenced by the following: During the morning medication administration on December 21, 2010, at 8:40 a.m., the licensed practical nurse (LPN) was observed making several attempts to administer 1 drop of Muro eye drops into Resident #3's right eye. The resident, however, was combative and refused to cooperate. Eventually, the LPN stopped trying and the resident did not receive the eye drop. (1) On December 21, 2010, at 10:05 a.m., review of Resident #3's current physician's orders (POs), dated December 1, 2010, indicated "Muro 128 5% Eye Drops. Instill 1 drop 3 times daily into left eye." The morning nurse, however, had tried administering the drop to his right eye. (2) Review of Resident #3's POs from previous months revealed that nursing staff failed to transcribe the orders for Muro eye drops accurately. (a) While his current POs, dated December 1, 2010, indicated the Muro eye drops were to be administered to his left eye, his December 2010	I 500	In the future the RN Coordinator will ensure all individuals on fluid restrictions will be monitored appropriately by way of documenting the amount of fluid intake during medication pass on the MAR chart and reviewed by the RN Coordinator on an on-going basis.....02-03-11 In the future the RN Coordinator will ensure that all nursing staff are provided on-going training and are in compliance with the fluid restriction protocol to ensure proper hydration. This training will be proved on a quarterly and as needed basis.....02-03-11	

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I 500	Continued From page 6 Medication Administration Record (MAR) had been altered; a line was drawn through the word left and "right" was written below it. On December 22, 2010, at 3:22 p.m., review of the resident's progress notes from December 2009 revealed that he was evaluated at a hospital emergency room (ER) for a swollen left eye and received sutures. The ER discharge papers indicated the Muro eye drops were ordered for the left eye. On December 22, 2010, at 3:25 p.m., neither the written record nor concurrent interviews with the afternoon LPN and the registered nurse (RN) could explain why the order had been altered to say "right" eye. (b) On December 22, 2010, beginning at 2:59 p.m., continued review of Resident #3's POs and MARs for the period December 2009 - December 2010 revealed that some of his POs indicated the eye drop should be administered to his left eye (March 2010, May, 2010, June 2010, August 2010, October 2010 and November 2010), whereas POs for April 2010 showed a line drawn through the word left, and "right" written instead. Simlarly, some of the resident's monthly MARs reflected designated administration times of 6am, noon and 6pm, while other MARs simply reflected the word "treatment" without indicating specific times. (c) Resident #3's POs for July 2010 and September 2010 had the notation of "D/C'd" written for the Muro eye drops. The alterations, however, were not dated. On December 22, 2010, at 3:22 p.m., there was no corresponding telephone order in his chart. Review of the resident's nurse progress notes failed to indicate why, or by whom, an order was given to discontinue the Muro eye drops. In addition, Resident #3's POs, dated October 1, 2010,	I 500		

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I 500	Continued From page 7 November 1, 2010 and December 1, 2010 all reflected "Muro 128 5% Eye Drops. Instill 1 drop 3 times daily into left eye." (3) On December 22, 2010, beginning at 2:59 p.m., review of Resident #3's POs for the period December 2009 - December 2010 revealed that an LPN, the RN and the primary care physician had all signed the monthly POs. There was no indication, however, that the resident's medical team identified transcription errors (left eye, right eye, designated treatment times, etc.) prior to this survey. (4) On December 22, 2010, at 11:07 a.m., Resident #3's day program nurse stated that the resident did not receive any medications or treatments during his day there. At 11:46 a.m., she presented Resident #3's POs for October, November and December 2010. They all reflected "Muro 128 5% Eye Drops. Instill 1 drop 3 times daily into left eye." The nurse, however, stated that she had not been instructed by the home to administer eye drops and because the orders read "three times daily," she would not administer them without first receiving orders to do so. When informed that on the previous morning (December 21, 2010, at 10:10 a.m.), the resident's MAR for December 2010 showed the designated times included a noon administration, the day program nurse expressed her willingness to administer the eye drops. When interviewed in the home later that afternoon, at 1:55 p.m., both the RN and the QMRP acknowledged that neither of them had addressed Resident #3's order for Muro eye drops with the day program. It should be noted that on December 22, 2010, at 3:30 p.m., the primary care physician discontinued the Muro eye	I 500	3. The medication administration nurse that failed to provide water to client #1 was re-trained to insure the medication pass procedures are followed consistently. All medication nurses received the training...1-4-11 The RN will observe medication administration at minimum once weekly to insure that all medications are properly administered routinely...1-24-11 4. All of the medication administration nurses were trained on all issues involving the administration of the eye drops including (1) insuring that the physician's orders are accurate and followed; (2) reporting refusal to accept medication (3) properly documenting and implementing verbal orders (4) coordination with day program services The eye drops have been discontinued at this time per the PCPs order...1-14-11 BRA began to pursue the needed wheelchair in June of 2010 as evidenced by the NRH summary attached. BRA did not have this documentation during the survey but subsequently requested it and received it after the survey was completed. Neither the RN nor QMRP notes reflected the follow up that had been done to that point and the Program Manager has addressed this with both the QMRP and RN. At this point, the new wheelchair has been developed and has been received. The PT has trained staff and the client on the use of the chair...1-3-11. Staff will be retrained on monitoring the condition of adaptive equipment and timely reporting to the RN on...1-20-11 Staff will continue to be required to examine adaptive equipment and report any issues they uncover but BRA has developed a new Adaptive Equipment Auditing and Tracking form that will be used to monitor the condition of all adaptive equipment on a monthly basis. This new form will be used by the RN and QMRP, raising the level of professionalism for these monthly reviews...1-20-11.	

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I 500	Continued From page 8 drops after receiving a telephone inquiry from the facility's RN seeking clarification. There was no evidence that the facility's nursing services effectively monitored his POs and MARs to ensure their accuracy and/or to determine the continued need for prescribed treatments such as Muro eye drops. 2. Based on observation, staff interview and record review, the facility failed to ensure that adaptive equipment was furnished and maintained in good condition as prescribed, for one of the two residents (out of six) who utilized wheelchairs for mobility. (Resident #1) The finding includes: During the Entrance conference on December 21, 2010, at approximately 11:36 p.m., interview with the QMRP and the facility coordinator (FC) revealed that the wheelchair used by Resident #1 was in good repair. His wheelchair, however, was not in good repair, as evidenced by the following: a. The facility failed to ensure that staff reported damaged wheelchairs to supervisors timely, as evidenced by the following: (1) On December 21, 2010, Resident #1 was observed at his day program, from 1:00 p.m. - 1:42 p.m. At 1:12 p.m., when asked about the condition of Resident #1's wheelchair, his assigned 1:1 direct support staff person stated that it was in good working order. She said a technician had made some repairs approximately 2 1/2 weeks earlier and that it was operational. However, a minute later (at 1:13 p.m.), inspection of the resident's wheelchair revealed that the	I 500		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 9 small plastic wheels were missing from the end of the right anti-tipper device. The 1:1 staff said she was previously unaware that any parts were missing. On December 23, 2010, at 10:53, the QMRP was asked about the facility's policies and systems for monitoring and repairing residents' adaptive equipment, specifically wheelchairs. She stated that direct support staff were expected to report any problems with adaptive equipment to the house manager (HM) or to the QMRP. The HM routinely inspected wheelchairs on a monthly basis, documenting the inspection on a 2-page form. The QMRP said she was not aware of any missing parts on Resident #1's wheelchair. The QMRP then asked the HM, who also stated that she was not aware of any missing parts on Resident #1's wheelchair. When the 1:1 staff person was reached by telephone, she informed the HM that the right anti-tipper wheels were missing and then acknowledged that she "forgot" to report it two days earlier. (2) On December 23, 2010, at 11:20 a.m., review of Daily Progress Notes that were entered into Resident #1's record by each shift revealed that for the past 10 days, staff routinely had checked "yes" at the place designated for "adaptive equipment working." None of the shift progress notes documented any concerns regarding the condition of Resident #1's wheelchair. [Note: Resident #1 received 1:1 staffing support 16 hours daily, during awake hours.] (3) On December 23, 2010, beginning at 11:38 a.m., review of staff in-service training records revealed no documented evidence that the facility provided training on wheelchair maintenance for its direct support staff.	I 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-088	A. BUILDING _____ B. WING _____	12/23/2010

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I 500	Continued From page 10 b. Interviews and review of Resident #1's record revealed that the facility failed to address timely the physical therapist's recommendation that he receive a custom wheelchair, as evidenced by the following: On December 23, 2010, beginning at 11:38 a.m., review of Resident #1's physical therapy (PT) records revealed that a PT Evaluation, dated January 22, 2010, indicated that his wheelchair "sling seating system" did "not fully support his body." The PT stated that the resident "may benefit from a custom wheelchair." In an updated evaluation, dated May 14, 2010, the PT recommended a custom wheelchair. Resident #1's Annual PT Evaluation, dated June 30, 2010, recommended the resident "will benefit from a custom wheelchair. Obtain a 719a form." Review of the resident's Individual Support Plan, dated July 13, 2010, revealed that his interdisciplinary team (IDT) adopted the PT's recommendation for a "customized wheelchair." Continued review of the record, however, failed to show evidence that the facility had pursued the new wheelchair. At 12:00 p.m., concurrent interviews with the QMRP, HM and the registered nurse (RN) revealed that an LPN (who worked solely out of the agency's corporate office) handled 719a forms and requests for adaptive equipment. During the interview, the RN spoke with the LPN by telephone. The telephone conversation, however, failed to clarify whether or not a 719a form had ever been signed by the primary care physician and forwarded to the insurance carrier. At 2:15 p.m., review of Resident #1's Annual Nursing Evaluation, dated July 10, 2010, revealed that the evaluation failed to reflect the status of	I 500		

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I 500	Continued From page 11 the resident's recommended custom wheelchair. The QMRP's monthly summary reports also failed to reflect the status of his wheelchair. At 2:20 p.m., the RN and the QMRP both acknowledged that they had not been actively monitoring Resident #1's wheelchair needs and did not know whether a new chair had been ordered. There was no evidence that the facility sought to acquire a customized wheelchair since the PT's recommendation was adopted by the IDT on July 13, 2010, five months earlier.	I 500		

Health Regulation Administration

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R 000	INITIAL COMMENTS A licensure was initiated on December 21, 2010 and was concluded on December 23, 2010. A sample of three residents was selected from a population of six men with various cognitive and intellectual disabilities. This survey was initiated utilizing the fundamental process. The findings of the survey were based on observations and interviews with clients and staff in the home and at three day programs, as well as a review of resident and administrative records, including incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and review of personnel records, the GHMRP, prior to employing an unlicensed person, failed to obtain a criminal background check for all jurisdictions in which the employee had worked or resided within the 7 years prior to the check, for 1 out of 19 direct support staff employed by the facility. The finding includes: Personnel records for all staff were reviewed on December 22, 2010, beginning at 4:29 p.m. Staff 1's record documented that on September 10, 2009, a background check had been obtained for the District of Columbia. Review of his	R 125	R125 The requested criminal background check for one staff in Maryland (based on Maryland residence) was completed on the final day of the survey (see attached copy)...12-22-11 BRA will insure in the future that all potential staff receives the appropriate background check prior to hire...2-1-11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Program Director — (X6) DATE: 01/04/11

Health Regulation Administration

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R 125	Continued From page 1 employment application form revealed that he had worked in Suitland, Maryland from February 2006 - January 2008. There was no evidence, however, that a background check had been obtained for that jurisdiction. During the Exit conference on the following afternoon (December 23, 2010), the facility coordinator indicated that no additional information was available.	R 125		